		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001099

Facility Name: HILLCREST HOME

Address: 14734 ILLINOIS HWY 82 (Number) GENESEO (City) IL 61254 (Zip Code)

County: HENRY

Telephone Number: (309) 944-2147 **Fax #** (309) 944-8417

IDPA ID Number: 36-6001257001

Date of Initial License for Current Owners: 6/10/56

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JAMES E. TAYLOR **Telephone Number:** (309) 762-3626

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MARY BERGREN
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) JAMES E. TAYLOR, MEMBER
(Firm Name & Address) CARPENTIER, MITCHELL, GODDARD & CO., LLC, 4915 21ST AVENUE A, MOLINE, IL 61265
(Telephone) 309 762-3626 Fax # 309 762-4465

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/29/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	953	1,350	573	2,876	8
9	SNF/PED					9
10	ICF	29,917	14,376		44,293	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,870	15,726	573	47,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/10/53

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 2,303

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/02 Fiscal Year: 11/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	354,686	18,404	10,640	383,730		383,730		383,730			1
2	Food Purchase		178,149		178,149		178,149	(1,953)	176,196			2
3	Housekeeping	159,627	6,807	926	167,360		167,360		167,360			3
4	Laundry	106,791	8,110		114,901		114,901		114,901			4
5	Heat and Other Utilities			125,885	125,885		125,885	(1,879)	124,006			5
6	Maintenance	93,502	19,800	39,826	153,128		153,128		153,128			6
7	Other (specify):*											7
8	**TOTAL General Services**	714,606	231,270	177,277	1,123,153		1,123,153	(3,832)	1,119,321			8
	B. Health Care and Programs											
9	Medical Director			1,350	1,350		1,350		1,350			9
10	Nursing and Medical Records	2,140,930	188,723	29,750	2,359,403	(78,611)	2,280,792	(40,866)	2,239,926			10
10a	Therapy	160,691	310	159,789	320,790		320,790	(252,150)	68,640			10a
11	Activities	56,062	2,430	9,475	67,967		67,967	(852)	67,115			11
12	Social Services	69,427	23	1,434	70,884		70,884		70,884			12
13	Nurse Aide Training					78,611	78,611	(13,816)	64,795			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,427,110	191,486	201,798	2,820,394		2,820,394	(307,684)	2,512,710			16
	C. General Administration											
17	Administrative	56,452			56,452		56,452		56,452			17
18	Directors Fees											18
19	Professional Services			46,940	46,940		46,940	(890)	46,050			19
20	Dues, Fees, Subscriptions & Promotions			12,470	12,470		12,470	(4,593)	7,877			20
21	Clerical & General Office Expenses	151,549	11,812	56,041	219,402		219,402	(26,907)	192,495			21
22	Employee Benefits & Payroll Taxes			745,799	745,799		745,799	(1,194)	744,605			22
23	Inservice Training & Education			1,067	1,067		1,067		1,067			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,519	102,519		102,519		102,519			26
27	Other (specify):*											27
28	**TOTAL General Administration**	208,001	11,812	964,836	1,184,649		1,184,649	(33,584)	1,151,065			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,349,717	434,568	1,343,911	5,128,196		5,128,196	(345,100)	4,783,096			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLCREST HOME #0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			210,835	210,835		210,835	(37,539)	173,296			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			210,835	210,835		210,835	(37,539)	173,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,760	2,760		2,760	(1,271)	1,489			38
39	Ancillary Service Centers			240,267	240,267		240,267	(86,008)	154,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8,721		8,721		8,721	(8,721)				41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		8,721	341,577	350,298		350,298	(96,000)	254,298			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,349,717	443,289	1,896,323	5,689,329		5,689,329	(478,639)	5,210,690			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,953)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,879)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(504)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(890)	19		18
19	Entertainment	(1,194)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,323)	21		24
25	Fund Raising, Advertising and Promotional	(4,593)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(13,816)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(427,487)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (478,639)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (478,639)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HILLCREST HOME

ID# 0001099

Report Period Beginning: 12/01/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC GENERAL OFFICE EXP	$ (140)	21	1
2	MEDICARE REIMBURSEMENTS	(86,008)	39	2
3	TELEPHONE CALLS CHARGED TO PATIENTS	(444)	21	3
4	TRANSPORTATION	(1,271)	38	4
5	OXYGEN REIMBURSEMENT	(40,866)	10	5
6	ACTIVITIES FEES	(852)	11	6
7	THERAPY REIMBURSEMENTS	(252,150)	10a	7
8	VENDING MACHINE	(8,721)	41	8
9	DEPRECIATION ADJUSTMENTS	(37,035)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(427,487)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,953)	0	0	0	0	0	0	0	0	0	0	(1,953)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,879)	0	0	0	0	0	0	0	0	0	0	(1,879)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,832)	0	0	0	0	0	0	0	0	0	0	(3,832)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(40,866)	0	0	0	0	0	0	0	0	0	0	(40,866)	10
10a	Therapy	(252,150)	0	0	0	0	0	0	0	0	0	0	(252,150)	10a
11	Activities	(852)	0	0	0	0	0	0	0	0	0	0	(852)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(13,816)	0	0	0	0	0	0	0	0	0	0	(13,816)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(307,684)	0	0	0	0	0	0	0	0	0	0	(307,684)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(890)	0	0	0	0	0	0	0	0	0	0	(890)	19
20	Fees, Subscriptions & Promotions	(4,593)	0	0	0	0	0	0	0	0	0	0	(4,593)	20
21	Clerical & General Office Expenses	(26,907)	0	0	0	0	0	0	0	0	0	0	(26,907)	21
22	Employee Benefits & Payroll Taxes	(1,194)	0	0	0	0	0	0	0	0	0	0	(1,194)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(33,584)	0	0	0	0	0	0	0	0	0	0	(33,584)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(345,100)	0	0	0	0	0	0	0	0	0	0	(345,100)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(37,539)	0	0	0	0	0	0	0	0	0	0	(37,539)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(37,539)	0	0	0	0	0	0	0	0	0	0	(37,539)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,271)	0	0	0	0	0	0	0	0	0	0	(1,271)	38
39	Ancillary Service Centers	(86,008)	0	0	0	0	0	0	0	0	0	0	(86,008)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(8,721)	0	0	0	0	0	0	0	0	0	0	(8,721)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(96,000)	0	0	0	0	0	0	0	0	0	0	(96,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(478,639)	0	0	0	0	0	0	0	0	0	0	(478,639)	45

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HENRY COUNTY, ILLINOIS	100	NONE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	N/A	8
	1998	N/A	9
	1999	N/A	10
	2000	N/A	11
	2001	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HOME COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0001099

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,394 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	6 ACRES	VARIOUS	$ 1,000	1
2					2
3	TOTALS	#VALUE!		$ 1,000	3

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	158		1971	1971	$ 415,304	$ 8,307	50	$ 8,307	$	$ 251,475	4
5	22		1976	1976	1,064,182	21,283	50	21,283		569,837	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1977	52,950	1,059	50	1,059		27,534	9
10	GENERAL			1979	6,552		3			6,552	10
11	GENERAL			1980	14,609	292	50	292		6,573	11
12	GENERAL			1981	61,074	1,221	50	1,221		26,258	12
13	GENERAL			1982	6,189		3			6,189	13
14	GENERAL			1983	79,248	1,317	.10-50	1,317		44,108	14
15	GENERAL			1984	46,106	856	.10-50	856		19,404	15
16	GENERAL			1985	76,531	1,692	.20-30	1,692		35,719	16
17	GENERAL			1986	76,930	2,610	.20-30	2,610		44,236	17
18	GENERAL			1987	120,391	4,013	30	4,013		63,956	18
19	GENERAL			1988	70,622	2,114	.12-40	2,114		32,093	19
20	GENERAL			1989	209,235	7,381	.20-40	7,381		99,386	20
21	GENERAL			1990	810,969	27,032	30	27,032		491,759	21
22	GENERAL			1991	336,390	11,213	30	11,213		199,365	22
23	GENERAL			1992	121,611	5,921	.5-20	5,921		65,359	23
24	GENERAL			1993	57,379	3,218	.5-20	3,218		35,263	24
25	GENERAL			1994	106,380	6,199	.10-20	6,199		52,695	25
26	GENERAL			1995	106,336	5,015	.10-40	5,015		38,157	26
27	RECOAT ROOF			1996	2,495	125	20	125		781	27
28	LIGHT FIXTURES			1996	1,855	186	10	186		1,209	28
29	HAND RAIL			1996	1,669		5			1,669	29
30	TUCK POINTING			1996	8,272	414	20	414		2,725	30
31	GARAGE			1996	5,708	142	40	142		769	31
32	AIR CONDITIONING			1997	35,751	1,788	20	1,788		9,387	32
33	COOLER			1997	18,258	913	20	913		5,326	33
34	BUILDING LIGHTS			1997	1,517	179	5	179		1,517	34
35	ROOF			1997	4,620	154	30	154		847	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PUMP HOUSE REPAIRS	1997	$ 800	$ 40	20	$ 40	$	$ 233	37
38	EXPAND LAGOON SYSTEM	1998	370,488	12,350	30	12,350		71,009	38
39	BOILER REPAIRS	1998	1,649	165	10	165		660	39
40	WATER HEATER	1998	3,550	355	10	355		1,716	40
41	ROOF	1998	5,477	274	20	274		1,233	41
42	GUTTERS	1998	5,767	288	20	288		1,416	42
43	EXPAND LAGOON SYSTEM	1999	46,155	2,308	10	2,308		7,479	43
44	BOILER REPAIRS	1999	23,138	2,314	10	2,314		6,942	44
45	HEATING MOTOR	1999	3,000	300	10	300		1,100	45
46	PARKING LOT LIGHTS	1999	1,284	128	10	128		512	46
47	CARPET	2000	2,626	263	10	263		592	47
48	WATER LINE REPAIR	2000	620	62	10	62		140	48
49	REFURBISH WASHERS	2000	3,168	317	10	317		819	49
50	A/C REPAIR	2000	6,781	678	10	678		1,695	50
51	WATER HEATER REPAIR	2000	5,425	543	10	543		1,493	51
52	REMODELING	2001	8,630	432	20	432		720	52
53	CONCRETE WORK	2001	1,512	151	10	151		164	53
54	GAS LINE REPAIR	2001	21,529	2,153	10	2,153		3,050	54
55	A/C REFURBISH	2001	4,169	417	10	417		695	55
56	HEAT REFURBISH	2001	7,859	786	10	786		1,179	56
57	WATER HEATER	2001	6,488	649	10	649		1,027	57
58	WATER HEATER	2001	5,551	555	10	555		1,018	58
59	A/C REFURBISH	2002	8,661	433	10	433		433	59
60	HEATER REFURBISH	2002	6,994	350	10	350		350	60
61	WATER HEATER	2002	2,562	43	10	43		43	61
62	SATELLITE	2002	14,037	351	10	351		351	62
63	IRON PUMP	2002	1,386	139	10	139		139	63
64	SHOWER ROOM REPAIR	2002	3,096	284	10	284		284	64
65	KICHENETTE ADDITION	2002	2,270	208	10	208		208	65
66	KICHENETTE ADDITION	2002	4,021	201	10	201		201	66
67	GARAGE PAINTING	2002	1,670	56	10	56		56	67
68	HOUSEKEEPING OFFICE ADDITION	2002	2,161	162	10	162		162	68
69	PRIVATE ROOMS REPAIR	2002	7,441	372	10	372		372	69
70	TOTAL (lines 4 thru 69)		$ 4,509,098	$ 142,771		$ 142,771	$	$ 2,247,639	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 291,979	$ 28,768	$ 28,768	$		$ 167,148	71
72	Current Year Purchases	45,766	1,757	1,757			1,757	72
73	Fully Depreciated Assets	614,144					614,144	73
74								74
75	TOTALS	$ 951,889	$ 30,525	$ 30,525	$		$ 783,049	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORT	1996 CHEVY VAN	1996	$ 34,005	$	$	$		$ 34,005	76
77										77
78										78
79										79
80	TOTALS			$ 34,005	$	$	$		$ 34,005	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,495,992	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,296	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 173,296	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,064,693	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	91 LUMINA/1991	$ 11,952	$	$ 11,952	86
87	94 CHEVY VAN/1994	18,472		18,472	87
88	97 LUMINA/1997	15,135	504	15,135	88
89					89
90					90
91	TOTALS	$ 45,559	$ 504	$ 45,559	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	94

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	41

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	467	2,467	400	3,334
3	Classroom Wages (a)	3,549	23,456		27,005
4	Clinical Wages (b)	78	10,232		10,310
5	In-House Trainer Wages (c)	5,479	17,217	13,416	36,112
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,850		1,850
9	TOTALS	$ 9,573	$ 55,222	$ 13,816	$ 78,611
10	SUM OF line 9, col. 1 and 2 (e)	$ 64,795			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	36
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	3
TOTAL TRAINED	50

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 953,998	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	720,806		3
4	Supply Inventory (priced at)	35,943		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ACCRUED INTEREST	869		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,711,616	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000		13
14	Buildings, at Historical Cost	5,082,371		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,031,452		16
17	Accumulated Depreciation (book methods)	(3,368,035)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,746,788	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,458,404	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,336	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,851		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 374,187	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 374,187	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,084,217	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,458,404	$	48

***(See instructions.)**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,198,301	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,198,301	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(605,875)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (605,875)	17
	B. Transfers (Itemize):		
18	**FICA REIMBURSEMENT**	251,921	18
19	**IMRF REIMBURSEMENT**	47,014	19
20	**INSURANCE REIMBURSEMENT**	192,856	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 491,791	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,084,217	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,563,514	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,563,514	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,150	6
7	Oxygen	40,866	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 293,016	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	18,182	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,953	14
15	Telephone, Television and Radio	444	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,579	23
	D. Non-Operating Revenue		
24	Contributions	26,912	24
25	Interest and Other Investment Income***	24,431	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,343	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	SEE ATTACHED SCHEDULE	155,002	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 155,002	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,083,454	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,123,153	31
32	Health Care	2,820,394	32
33	General Administration	1,184,649	33
	B. Capital Expense		
34	Ownership	210,835	34
	C. Ancillary Expense		
35	Special Cost Centers	251,748	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,689,329	40
41	**Income before Income Taxes (line 30 minus line 40)****	(605,875)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (605,875)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,755	2,080	$ 53,430	$ 25.69	1
2	Assistant Director of Nursing	1,733	2,080	49,505	23.80	2
3	Registered Nurses	8,757	10,145	180,271	17.77	3
4	Licensed Practical Nurses	31,957	36,538	560,794	15.35	4
5	Nurse Aides & Orderlies	93,731	104,250	925,128	8.87	5
6	Nurse Aide Trainees	22,556	24,308	175,906	7.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,874	6,824	56,062	8.22	10
11	Social Service Workers	5,141	6,208	69,427	11.18	11
12	Dietician					12
13	Food Service Supervisor	3,624	4,160	58,456	14.05	13
14	Head Cook	5,758	7,264	66,613	9.17	14
15	Cook Helpers/Assistants	27,112	30,420	229,616	7.55	15
16	Dishwashers					16
17	Maintenance Workers	8,706	10,217	98,361	9.63	17
18	Housekeepers	17,822	19,685	159,627	8.11	18
19	Laundry	11,821	13,311	106,791	8.02	19
20	Administrator	1,738	2,081	56,452	27.13	20
21	Assistant Administrator					21
22	Other Administrative	16,119	18,841	286,326	15.20	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	7,082	8,448	82,072	9.71	30
31	Medical Records	5,437	6,223	56,261	9.04	31
32	Other Health Care(specify)					32
33	Other(specify) THERAPY NURS	3,848	4,821	78,619	16.31	33
34	TOTAL (lines 1 - 33)	280,571	317,904	$ 3,349,717 *	$ 10.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	180	$ 8,085		35
36	Medical Director	15	1,350		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	650		39
40	Physical Therapy Consultant	77	3,850		40
41	Occupational Therapy Consultant	84	4,175		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	13	1,120		45
46	Other(specify) QA PHYSICIAN	8	200		46
47	WASTE TREATMENT PLANT	48	3,900		47
48	WATER TREATMENT	48	2,957		48
49	TOTAL (lines 35 - 48)	521	$ 26,287		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY BERGREN		0.00	$ 56,452
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,452

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DUANE MORRIS	LEGAL FEES	$ 40,325
CMG & COMPANY	COST REPORT/AUDIT	5,725
IDPH	FINES/PENALTIES	890
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 46,940

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,337
Unemployment Compensation Insurance	
FICA Taxes	251,921
Employee Health Insurance	354,651
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	47,014
PHYSICALS	125
NEEDLES STICK	152
INSURANCE DEDUCTIBLE	375
NAMETAGS	30
EMPLOYEE RECOGNITION	1,194
LESS: ENTERTAINMENT	(1,194)
TOTAL (agree to Schedule V, line 22, col.8)	$ 744,605

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,084
Health Care Worker Background Check	1,252
(Indicate # of checks performed 104)	
PUBLIC RELATIONS	4,593
DUES & SUBSCRIPTIONS	2,541
Less: Public Relations Expense	(825)
Non-allowable advertising	(3,768)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,877

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/01 Ending: 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **COUNTY NURSING HOME ASSN - $1370**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **45,686** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **98,550**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **1,953**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **NO** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

HILLCREST HOME
ID#0001099

YEAR ENDED 11/30/02

SCHEDULE XVII - INCOME STATEMENT

E. OTHER REVENUE

	AMOUNT
MEDICARE PHARMACY PART A	57,363
MEDICARE LAB	2,495
MEDICARE RADIOLOGY	816
MEDICARE MISCELLANEOUS PART B	22,422
MEDICARE ME SUPPLIES PART A	2,911
VENDING MACHINE	16,878
NURSING SUPPLIES	38,754
TRANSPORTATION	1,271
ACTIVITIES FEES	852
MISCELLANEOUS	11,240
TOTAL	155,002

HILLCREST HOME
ID# 0001099

YEAR ENDED 11/30/02

SCHEDULE XIII - NURSE AIDE TRAINING

OTHER FACILITIES FOR WHICH AIDES WERE TRAINED:

GOOD SAMARITAN CENTER
704 SOUTH ILLINOIS
GENESEO, IL 61254

PROPHETS RIVERVIEW GOOD SAMARITAN
310 MOSHER
PROPHETSTOWN, IL 61277

ILLINI HOSPITAL
801 HOSPITAL RD
SILVIS, IL 61282